Arizona Department of Health Services Office for Children with Special Health Care Needs Children's Rehabilitative Services Administration	**Effective Date: 02/01/2007** **Last Review Effective Date: 02/13/2008**
SUBJECT: Quality Management	SECTION: QM 1.4

SUBTITLE: Credentialing/Re-credentialing

POLICY:

Children's Rehabilitative Services Administration (CRSA) will ensure that providers of services to Children's Rehabilitative Services (CRS) recipients are appropriately initially credentialed and re-credentialed and when necessary providers may be temporarily or provisionally credentialed.

STANDARD:

1) CRSA requires that all CRS Contractors have a written system in place for credentialing and re-credentialing providers in their contracted provider network.

2) Statement of non-discrimination:
CRSA credentialing and re-credentialing processes do not discriminate against:
   a) A health care professional, solely on the basis of license or certification or
   b) A health care professional who serves high risk populations or who specializes in the treatment of costly conditions.

3) CRSA ensures compliance with Federal requirements that prohibit employment or contracts with providers excluded from participation under either Medicare or Medicaid.

4) Definition of providers:

   The following health care professionals are required to have documented credentialing and re-credentialing:
   a) Physicians (MDs, DOs, and DPMs);
   b) Nurse Practitioners, Physicians Assistants, or Certified Midwives providing primary care services, including prenatal and delivery services;
   c) Dentists;
   d) Psychologists (Master's level and above); and
   e) Other independent behavioral health professionals who contract directly with the site.

5) Accreditation with national accrediting bodies, "Deemed Status":

   Accreditation of the Contractor with either the National Committee for Quality Assurance (NCQA) or the Joint Commission on Accreditation of Healthcare

Organizations (JCAHO) will demonstrate that credentialing and re-credentialing requirements have been met.

6) Delegation:
CRSA maintains the right and responsibility for over-site regarding delegated credentialing or re-credentialing decisions according to the Arizona Health Care Cost Containment System (AHCCCS) Medical Policy Manual, Chapter 900, Policy 950.

7) Contractors not accredited as described above in (5):
Contractors not accredited as described above must, at a minimum, maintain the standards as outlined in this policy.

8) Contractors not accredited as above in (5) must have written policies and procedures which:
   a) Address the scope, criteria, timeliness, and process for credentialing and re-credentialing providers;
   b) Must meet AHCCCS requirements and be reviewed and approved by CRSA;
   c) Reflect the direct responsibility of the Contractors' Medical Director or other designated physician for the oversight of the process and delineate the role of the credentialing committee;
   d) Indicate the utilization of participating providers in making credentialing decisions;
   e) Describe the methodology to be used by the Contractor's staff and Medical Director to provide documentation that each credentialing and re-credentialing file was completed and reviewed prior to presentation to the credentialing committee for evaluation;
   f) Indicate that individual credentialing/re-credentialing files will be maintained for each credentialed provider. Each file must include:
      i) Initial credentialing and all subsequent re-credentialing applications;
      ii) Information gained through credentialing and re-credentialing queries; and
      iii) Any other pertinent information used in determining whether or not the provider met the Contractor's credentialing and re-credentialing standards.

9) Contractor must conduct timely verification of information, as evidenced by notification of provider of approval status within 180 days of receipt of complete application.

PROCEDURES:

1) Initial credentialing:
Policies and procedures for the initial credentialing of physicians and other licensed health care providers must include:
   a) A written application to be completed, signed, and dated by the provider that attests to the following:

i) Reasons for any inability to perform the essential functions of the position, with or without accommodation;
ii) Lack of present illegal drug use;
iii) History of loss of license and/or felony convictions;
iv) History of loss or limitation of privileges or disciplinary action;
v) Current malpractice insurance coverage;
vi) Attestation by the applicant of the correctness and completeness of the application;
vii) Minimum five year work history;
viii) Drug Enforcement Administration (DEA) or Chemical Database Service (CDS) certification.

b) Verification from primary sources of:
i) Licensure or certification;
ii) Board certification, if applicable, or highest level of credentials attained; or
iii) Documentation of graduation from an accredited school and completion of any required internships/residency programs, or other postgraduate training, if the provider's school information is listed in member materials or Website.
iv) National Provider Databank (NPDB) query or, in lieu of the NPDB query, all of the following must be verified:
1) Minimum five year history of professional liability claims resulting in a judgment or settlement;
2) Disciplinary status with regulatory board or agency; and
3) Medicare/Medicaid sanctions.
4) Behavioral health providers may request a copy of their transcript or proof of education from their education institution and deliver it themselves in sealed envelope.

2) Temporary/Provisional credentialing:
Temporary, or provisional, credentialing is intended to expand the available provider network of providers in medically underserved areas, either rural or urban.

Contractors must have policies and procedures to address temporary or provisional credentials when it is in the best interest of members that providers be able to provide care prior to completion of the entire credentialing process.

Those policies must reflect the following:
a) "Initial Credentialing" guidelines (1)(a) and (b) above must be followed when granting temporary or provisional credentialing. The Contractor shall have 14 days after receiving a complete application, accompanied by the minimum documents identified above, within which to make a decision regarding the granting of temporary or provisional credentials.

A provider requesting temporary or provisional credentialing must complete a signed application which must, at a minimum include:

i) Reasons for any inability to perform the essential functions of the position, with or without accommodation;
ii) Lack of present illegal drug use;
iii) History of loss of license and/or felony conviction;
iv) History of loss or limitation of privileges or disciplinary action;
v) Current malpractice insurance coverage;
vi) Attestation by the applicant to the correctness and completeness of the application;
vii) Work history for the past five years; and
viii) Current DEA or CDS certificate.

b) The Contractor must have primary verification of the following:
i) Licensure or certification;
ii) Board certification, if applicable, or the highest level of credential attained; and
iii) National Provider Data Bank(NPDB) Query or in lieu of the NPDB query, all of the following:
1) Minimum five year history of professional liability claims resulting in judgment or settlement; and
2) Disciplinary status with regulatory or agency; and
3) Medicare/Medicaid sanctions.

c) The Medical Director of the Contractor will review the information included in the application and determine whether to grant provisional credentials.

d) Following approval of provisional credentials, the process of verification and committee review, as outlined in this policy should be completed.

3) Re-credentialing individual providers:

The Contractor must have policies which address re-credentialing policies for physicians and other licensed health care providers. At a minimum, the policies and procedures should include requirements for:

a) Re-credentialing at least every three years;

b) An update of information obtained during the initial credentialing for sections (1)(a) (except for (1)(a)(iii), with (1)(b)(ii) required only if board certified);

c) A process for ongoing monitoring and intervention, if appropriate, of providers sanctions, complaints, and quality issues pertaining to the provider, which include at a minimum, review of:
i) Medicare/Medicaid sanctions;
ii) State sanctions or limitations on licensure;
iii) Member concerns, which include grievances (complaints) and appeals information; and
iv) Utilization management information (such as: emergency room utilization, hospital length of stay, disease prevention, pharmacy utilization)
v) Performance improvement and monitoring (such as: performance measure rates)
vi) Results of medical record review audits

4) Credentialing organizational providers:
CRSA shall ensure that organizational providers who give services to CRS recipients are appropriately credentialed and re-credentialed.

Each Contractor must validate and re-validate at least every three years that the organizational provider:

a) Is licensed to operate in the state and is in compliance with any other applicable State or Federal requirements, and
b) Is reviewed and approved by an appropriate accrediting body or if not accredited, Center for Medicare and Medicaid Services (CMS) certification or state licensure review may substitute for accreditation. A copy of the report is required for verification.

5) Notification requirement:
CRSA Quality Management/Performance Improvement policy on Peer Review outlines the procedure for reporting to appropriate authorities any known serious issues and/or quality deficiencies that could result in a provider's suspension or termination from the network.

a) The Contractor must maintain documentation of implementation of the procedure, as appropriate
b) The Contractor must have an appeal process for instances in which the Contractor chooses to alter the provider's contract based on issues of quality of care and/or service, and
c) The Contractor must inform the provider of the appeal process.

Approved:	Date:
CRSA Administrator	2/18/08
CRSA Medical Director	2/19/08